COUNCIL FOR MEDICARE INTEGRITY

Medicare Oversight Scaled Back: What Can RACs Review?

At current spending levels Medicare Trustees predict the program will be able to cover hospital insurance benefits for seniors only until 2029. After that, Medicare will be forced to either reduce hospital coverage to 88 percent of what is covered today or Congress will have to cut payments to providers, raise costs to beneficiaries, or find additional funding elsewhere to extend the life of the Trust Fund.

Medicare's looming insolvency is due to a combination of factors – rising healthcare costs, increasing numbers of beneficiaries and fraud within the program. But simple billing errors **cause the program to lose $41 billion each year.**

The billing error rate in Medicare stands at 11 percent. This is not fraud but rather simple medical billing errors that fall through the cracks. If the program could recover a significant portion of these improper payments, the funds could go far to ensuring seniors do not experience the expected cuts in their health coverage after 2029.

Medicare Billing Oversight Has Been Gutted

Medicare billing oversight was significantly scaled back in recent years, reducing the work of Recovery Audit Contractors (RACs) to identify and return improper payments to the Medicare Trust Funds. Currently, Recovery Auditors can review a mere 0.5 percent **of Medicare provider claims within the scope of less than 25 Medicare claim types** (down from 800 claim types initially).

Additionally, RACs are only permitted to recommend a maximum of 6 new audit issue areas to CMS per month – preventing the program from scaling up to recover more misspent tax dollars. Continuing to allow improper payments to drain more than $40 billion per year is completely counter to the reality of looming Medicare Part A insolvency.

But new leadership at the Centers for Medicare & Medicaid Services (CMS) has the opportunity to take action and address the problem of improper payments, including adopting recommendations from the U.S. Government Accountability Office (GAO) to recover more misspent Medicare dollars. This includes having RACs conduct pre-payment reviews to stop improper payments before they occur.

Hundreds of error-prone audit scenarios, previously approved by CMS for review, have not been re-authorized for review under the new RAC contracts – leaving billions of improper payments unrecovered. Simple error scenarios should could be fast tracked for audit approval, including issues like:

CLINICAL VALIDATION

A physician documents "possible pneumonia" but the patient turns out to have an upper respiratory infection and the medical record does not demonstrate clinical evidence of pneumonia. Based on the physician's initial notes, however, the billing coder enters the code for "pneumonia" on the claim and the resulting claim causes an overpayment.

PHARMACY AUDITS

A drug is administered in 6mg increments. CMS billing guidelines say 1 billing unit equals a 6mg dose. The provider incorrectly billed 6 units even though only 6mg was provided to the patient – creating an overpayment of 6 times the correct amount. These cases are common and have very low appeals rates.

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Medicare auditing must be expanded to protect program solvency and full healthcare coverage benefits for American seniors.

Recovery Auditing is Vital to Securing Medicare's Financial Future

Recovery auditing is a tool proven to be very successful for the Medicare program and it requires no upfront cost to the government. Since Congress mandated the RAC Program, more than $10 billion in improper payments have been returned to the Medicare Trust Fund and more than $800 million in underpayments have been paid out to providers – balancing Medicare's checkbook and ultimately extending the life of the program by two full years.

Private health insurance companies do not tolerate rampant billing errors and neither should Medicare. Considered a basic cost of doing business, the same providers billing Medicare comply, without issue, with the nearly 100 percent claim review requirements of private health insurance companies.

Increase Medicare Billing Oversight to Protect the Trust Funds

In the short term, we must increase both the number of claim types RACs can review and the percentage of claims that can be reviewed within those claim types. We recommend that additional document request (ADR) limits be raised to 5 percent and new billing issue areas be approved for review by CMS. For example, DRG reviews, which are very clearly correctly billed or not, should no longer be artificially limited.

Consistent with CMS's priority on making government more efficient, the RAC audit scenario review process must be revisited to allow audits to proceed again on issues that were previously approved for review by CMS.

Finally, CMS should heed the consistent recommendations from the Government Accountability Office (GAO) urging the agency to add a new RAC prepayment review program to ensure Medicare claims are accurate before they are paid, preventing improper payments from going out the door in the same way private insurers do.

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